

Iowa Department of Human Services

**APPLICATION FOR AUTHORIZATION TO MAKE PRESUMPTIVE
MEDICAID ELIGIBILITY DETERMINATIONS FOR PREGNANT WOMEN**

Provider Name: _____

Address: _____

Email address: _____

Telephone: () _____

National Provider Number: _____

Please check all that apply:

1. Are you currently enrolled in Iowa's Medicaid program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you provide the following services?		
A. Outpatient hospital services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Rural health clinic services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Clinic services furnished by or under the direction of a physician	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you receive direct funds (not subcontract) under any of the following?		
A. Migrant health centers (under Section 329 or 330 of the Public Health Services Act)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Community health centers (under Section 329 or 330 of the Public Health Services Act)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Maternal and child health centers (under Title V of the Social Security Act)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Health services for urban Indians (under Title V of the Indian Health Care Improvement Act)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, attach a copy of the award letter or other verification of funding.		
4. Do you participate in any of the following programs?		
A. Special Supplemental Food Programs for Women, Infants and Children (WIC)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Commodity Supplemental Food Program	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. A state perinatal program	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, attach a copy of documentation showing your agency's participation in the program.		
5. Are you an Indian Health Service or a health program or facility operated by a tribe or tribal organization under the Indian Self Determination Act?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For provider eligibility reviews only: If your answer to Question 2,3,4, or 5 above recently changed from Yes to No, list the service/funding/program participation that changed and the date of the change. _____ - ____/____/____ (Month) (Day) (Year)		

The Provider acknowledges the information provided above to be accurate and complete

Provider Signature	Date
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